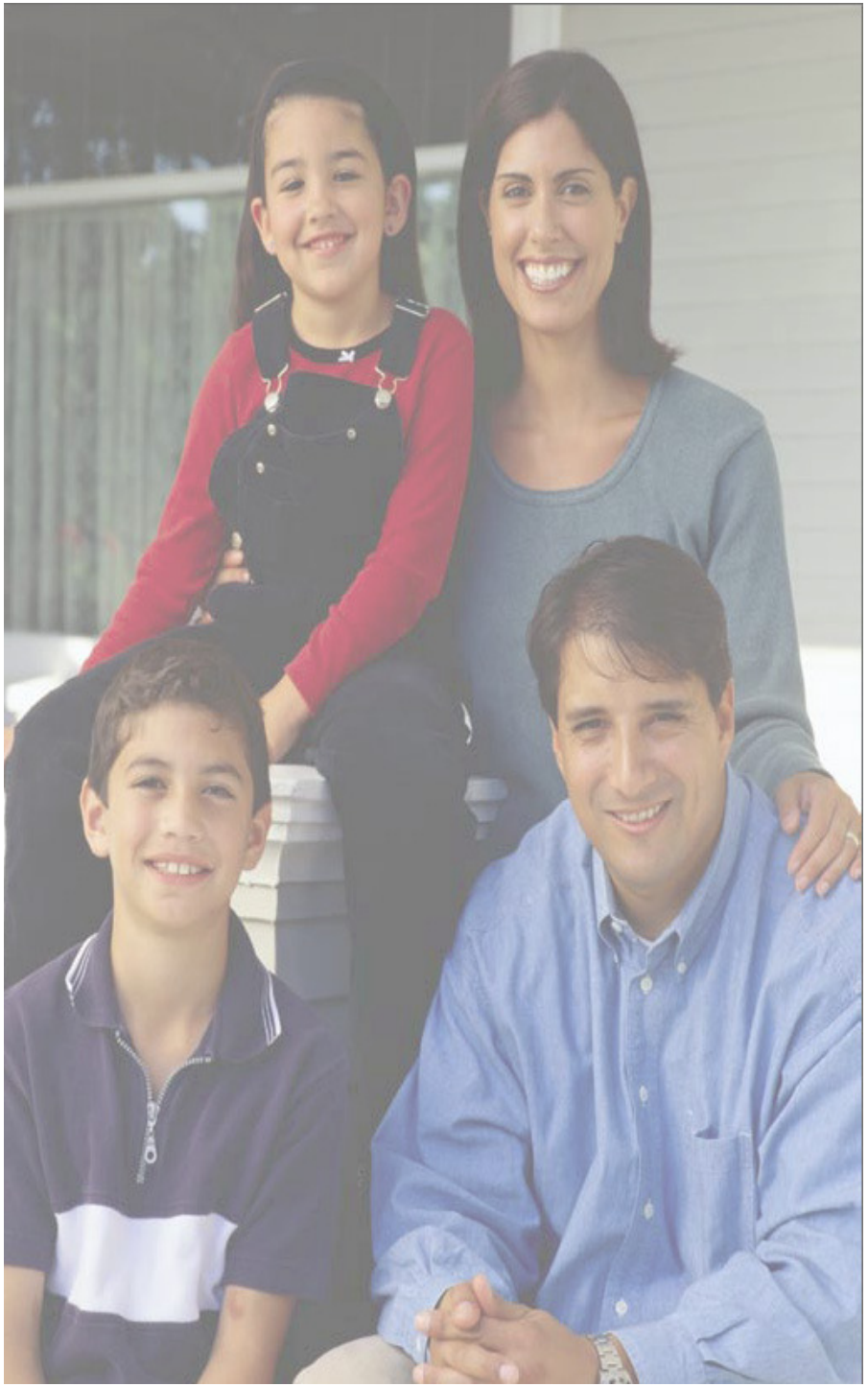


MCM Commission

Nick Toumpas

NH Department of Health and Human Services

New Hampshire MCM MEDICAID CARE MANAGEMENT

June 11, 2015

Merrimack County Nursing Home

Agenda

- Monthly Enrollment Update
  - MCM Step 1
  - NH HPP
- Key Indicator Report
- Step 2 data
  - Training Update
  - MCO Readiness update
- Q&A from Commission and Public

Setting the Context

Care Management Program

December 1, 2013 –June 1, 2015

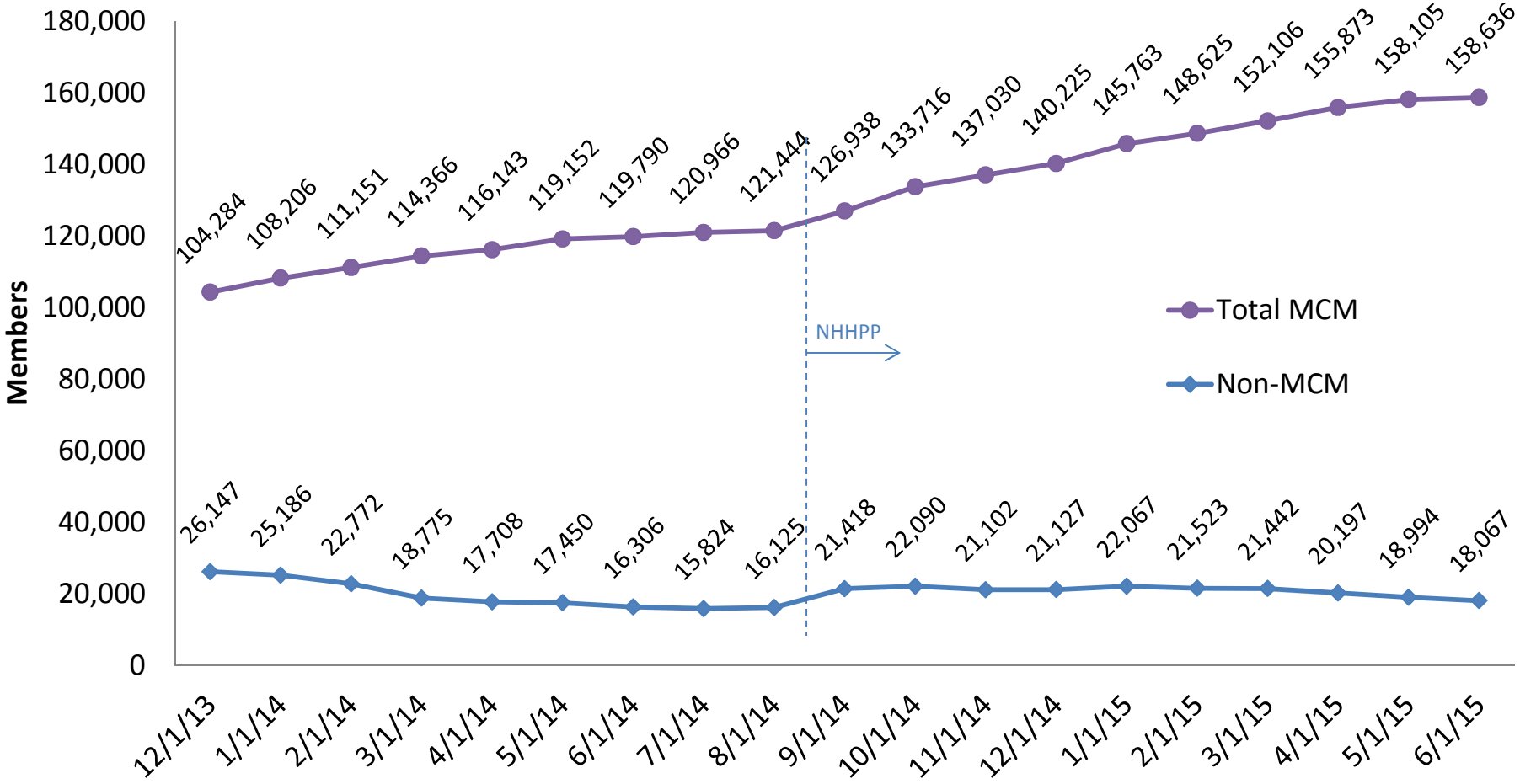
@ 19 Months

Guiding Principles of NH MCM

- Whole person management and care coordination
  - Foundation for Medicaid transformation
- Increase quality of care – right care, at the right time, in the right place to improve beneficiary health and quality of life
- Payment reform opportunities
- Budget predictability
- Purchasing for results and delivery system integration

MCM Monthly Enrollment Update

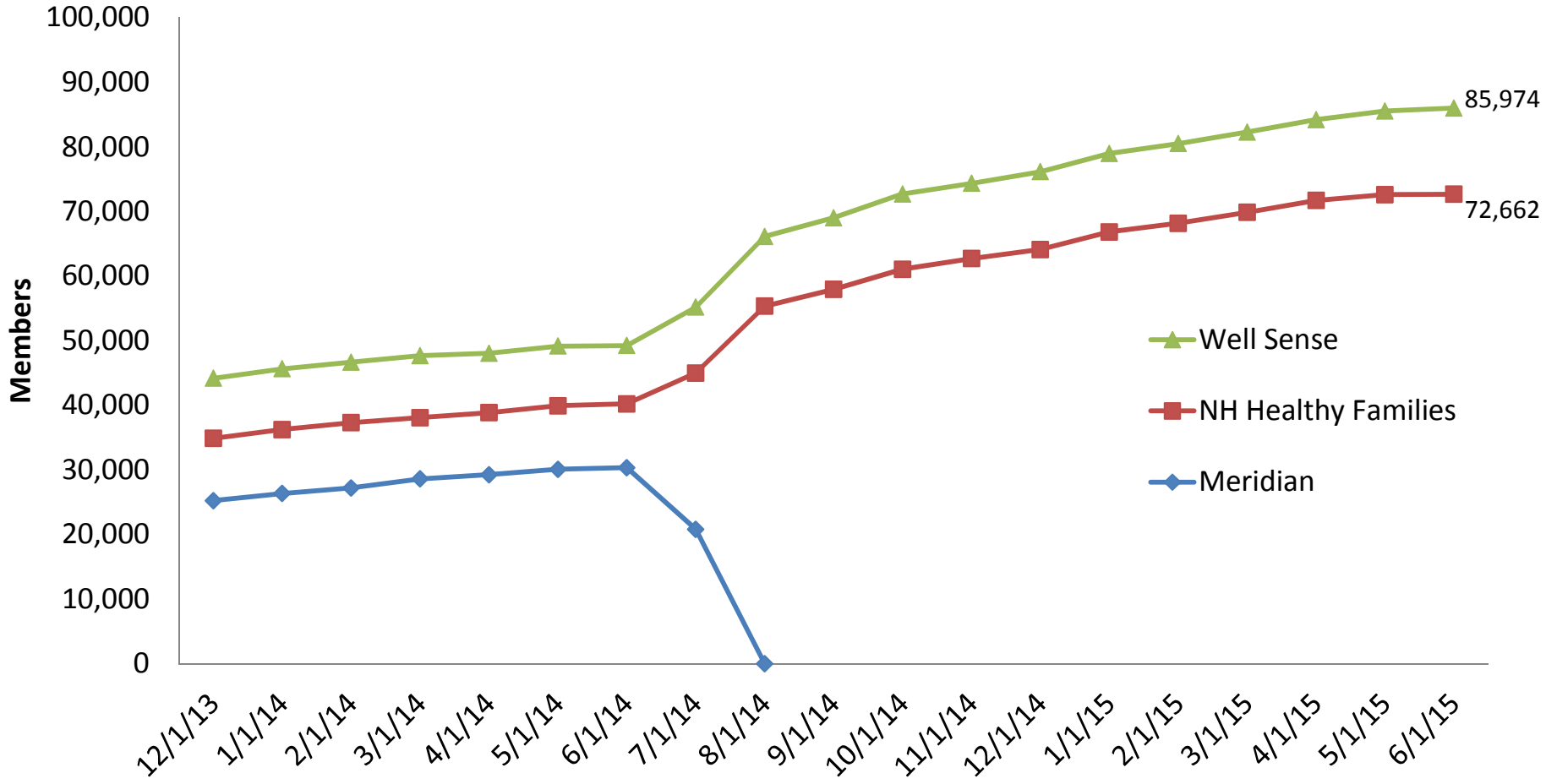
NH Medicaid Care Management Enrollment, 12/1/13 – 6/1/15



Note: Excludes members without full Medicaid benefits (Family Planning Only & Medicare Savings Plans)

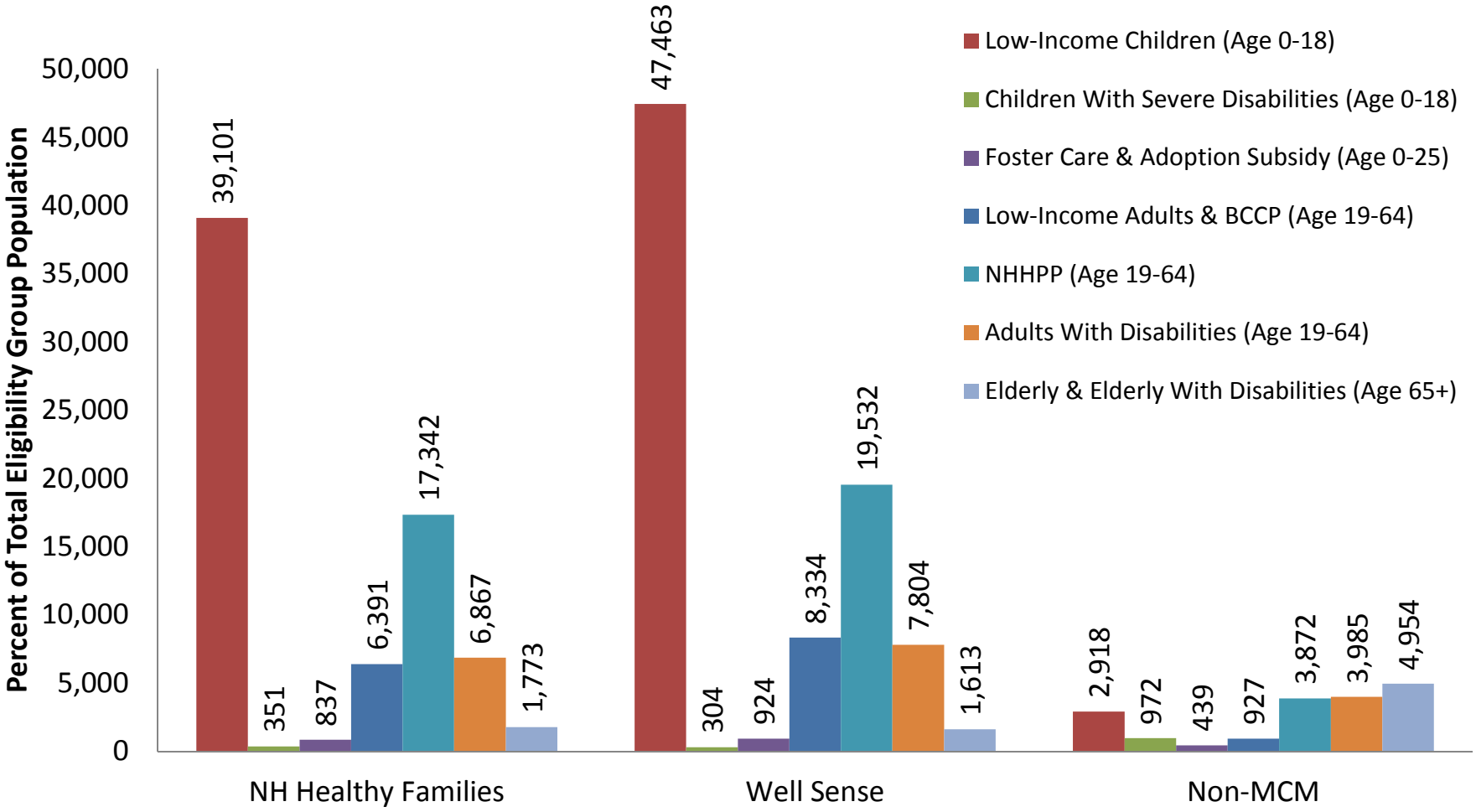
Source: NH MMIS as of 6/2/15 for most current period; Data subject to revision.

NH Medicaid Care Management Enrollment by Plan, 12/1/13 – 6/1/15



Source: NH MMIS as of 6/2/15 for most current period; Data subject to revision.

NH Medicaid Care Management by Eligibility Group, 6/1/15



Note: Excludes members without full Medicaid benefits (Family Planning Only & Medicare Savings Plans). Non-MCM includes members transitioning into MCM

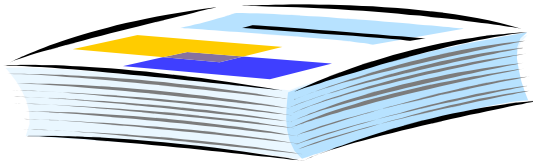
Source: NH MMIS as of 6/2/15; Data subject to revision.

NH Health Protection Program
&
Other Updates

NH HPP Update
As of 6/5/2015

- Total Recipients
  - 40,476
  - 20,000 are new to DHHS
    - 10,425 are new to NH HPP but have been clients in the past
- Benefit Plans
  - 37,882 are in the ABP (Alternative Benefit Plan)
  - 2,168 of Medically Frail are in the ABP
  - 426 of Medically Frail in standard Medicaid
- Care Management / HIPP
  - 337 Enrolled in HIPP
  - 212 are Potential HIPP
- Bridge
  - 19,527 are enrolled in WSHP
  - 17,338 are enrolled in NHHF
  - 3,062 are in Fee For Service/not yet enrolled in a plan

Key Performance Indicator Report

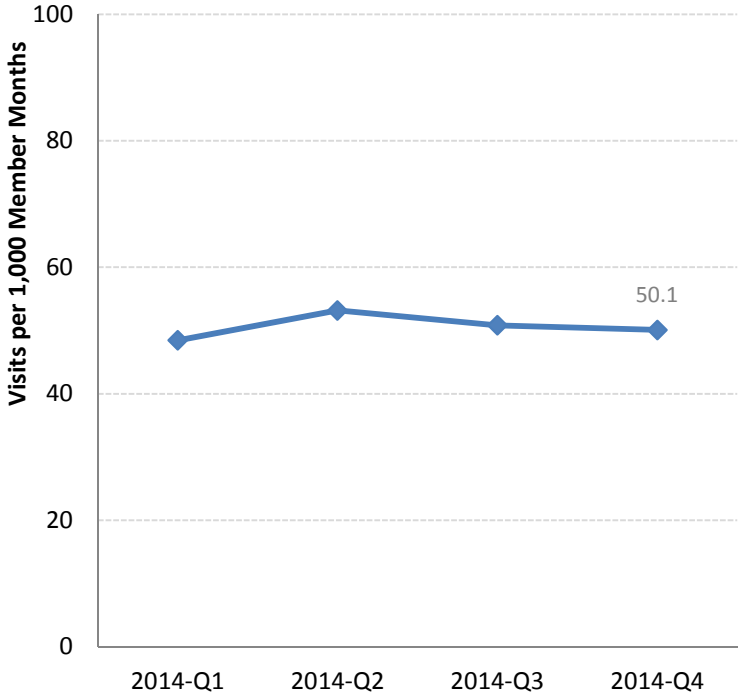


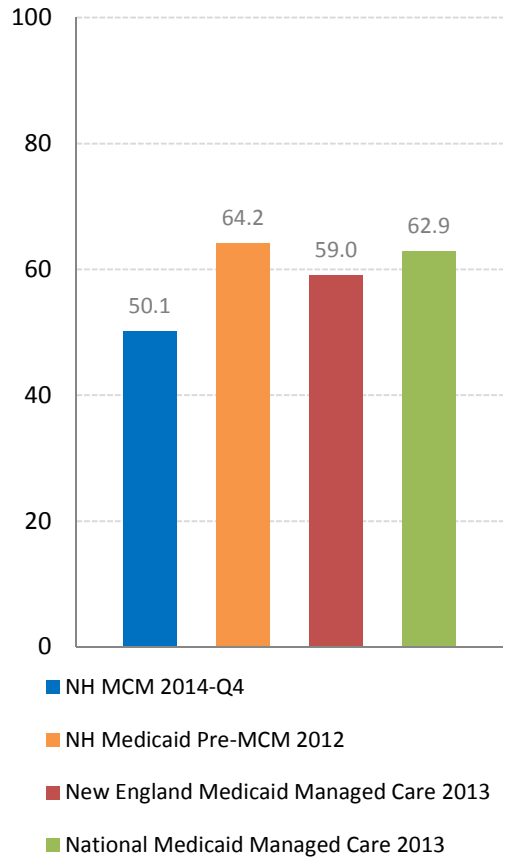
MCM Key Indicators

Metrics in the Key Indicators Report include:

- Access & Use of Care
- Customer Experience of Care
- Provider Service Experience
- Utilization Management
- Grievance & Appeals
- Preventative Care
- Chronic Medical Care
- Behavioral Health Care
- Substance Use Disorder Care
- General

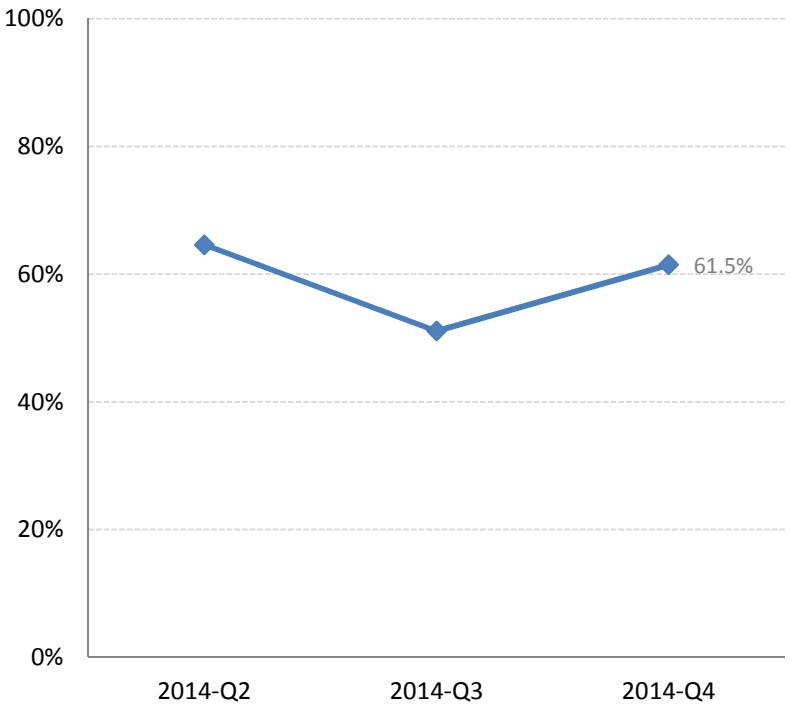
Emergency Department (ED) Visits

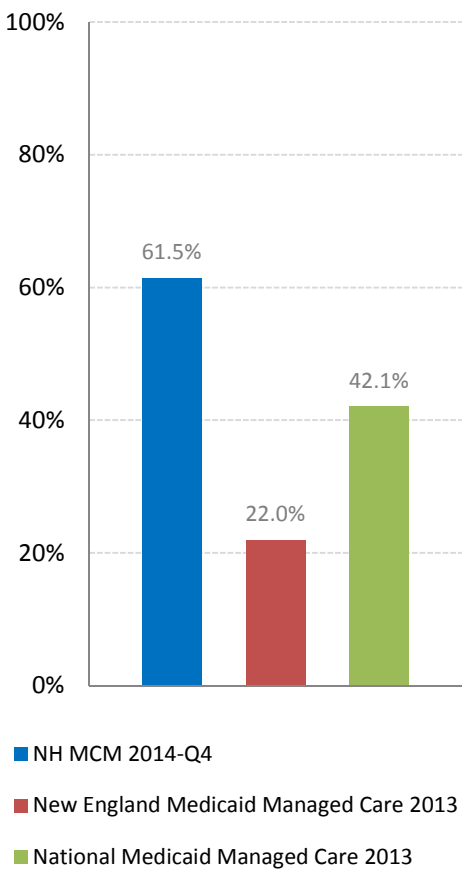




- Utilization of the emergency department indicates that members are using the ED at a lower rate than NH Medicaid Pre-MCM.
- NH Health Protection Population is excluded from this measure.

New Hampshire Hospital Members with Follow-up Appointments 7 Calendar Days Post Discharge





- The rate of follow-up appointments after a discharge from NH Hospital has increased to rates higher than Pre-MCM, National and New England Medicaid Managed Care rates.
- NH Health Protection Population is excluded from this measure.

Pharmacy Service Authorization Requests and Decisions, Follow Up

	2014 Q1			2014 Q2			2014 Q3			2014 Q4		
Average Membership	111,241			118,362			123,116			136,990		
	Requests	Denial	% Denial	Requests	Denial	% Denial	Requests	Denial	% Denial	Requests	Denial	% Denial
Pharmacy	8,609	2,314	27%	9,091	1,744	19%	10,543	3,852	37%	7,030	2,817	40%

- Additional information on the pharmacy service authorization denial rate from one MCO indicates that:
  - 59% of denials are being given for business reasons (i.e., a preferred drug is available, there is no coverage for the drug requested)
  - 41% of denials are for clinical indications (e.g., medical necessity not met).

Future of the MCM Key Indicators Report

- Key Indicator report one of many MCM reports and activities, including
  - EQRO/External Quality Review Organization Contract Compliance Report (June)
  - EQRO Technical Report (November)
  - Focus Groups (Spring/Fall)
  - HEDIS/Healthcare Effectiveness Data and Information Set (Summer)
  - CAHPS/Consumer Assessment of Healthcare Providers and Systems (Summer)
  - Provider Survey (Late Fall)
  - DHHS MCM Quality Team internal review (Monthly)
  - DHHS MCM Quality Team and health plan reviews Monthly)
  - MQIS/Medicaid Quality Indicators System (website)

- Key Indicators Changes
  - Redesign to include more outcomes
  - Transition to a quarterly report

- Next Steps
  - No August Report
  - Reporting quarters to be March/June/September/December
  - September presentation on
    - HEDIS
    - CAHPS
    - MQIS

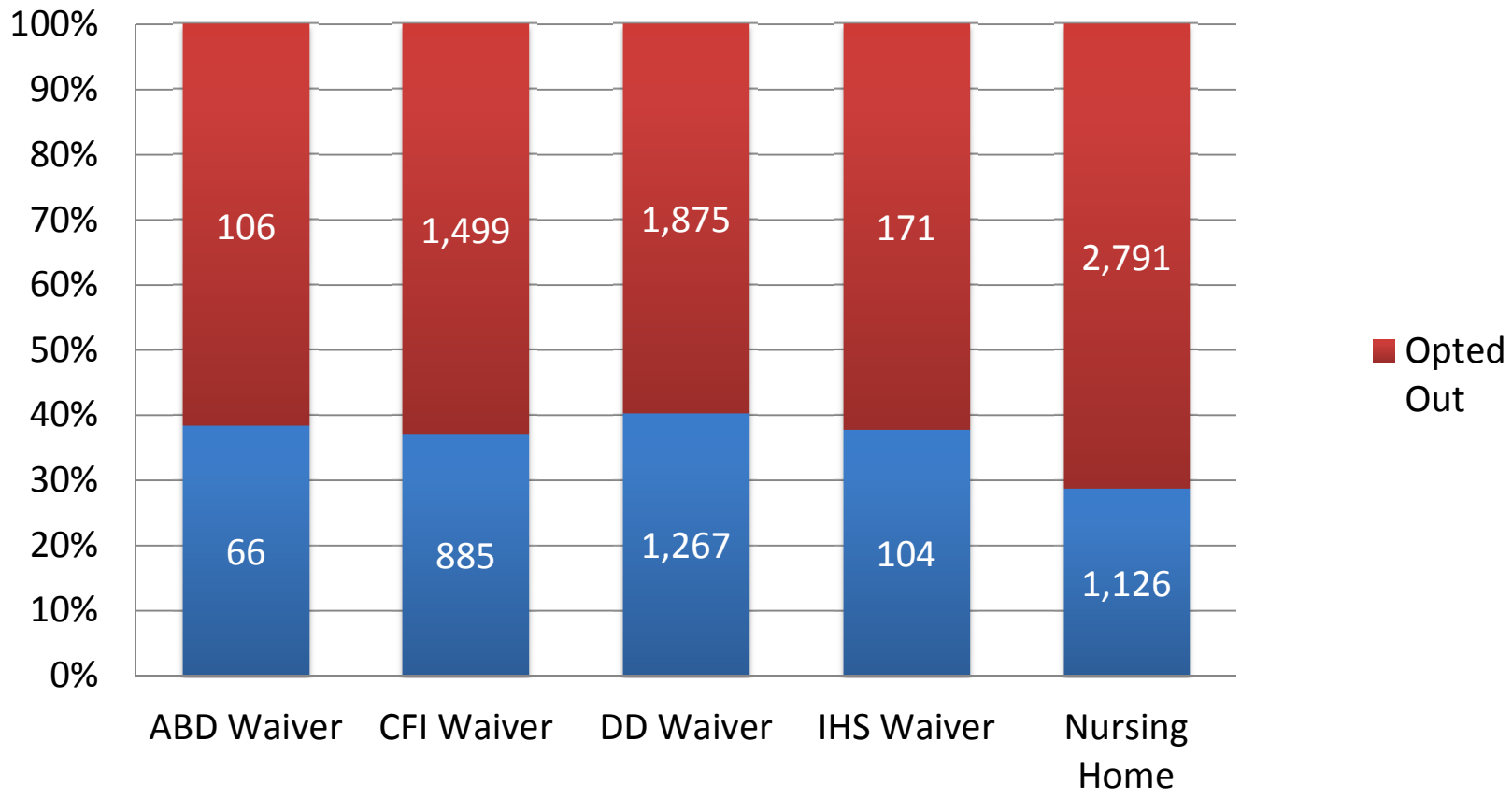
Step 2 Training and Education Update, MCO Readiness Update

Step 2, Phase 1
Mandatory Enrollment for Medical Services

- Individuals who were “voluntary” or who “opted out” in Step 1 require a high level of planning, education and outreach

- This education and outreach will be at the individual, provider , MCO and Department level

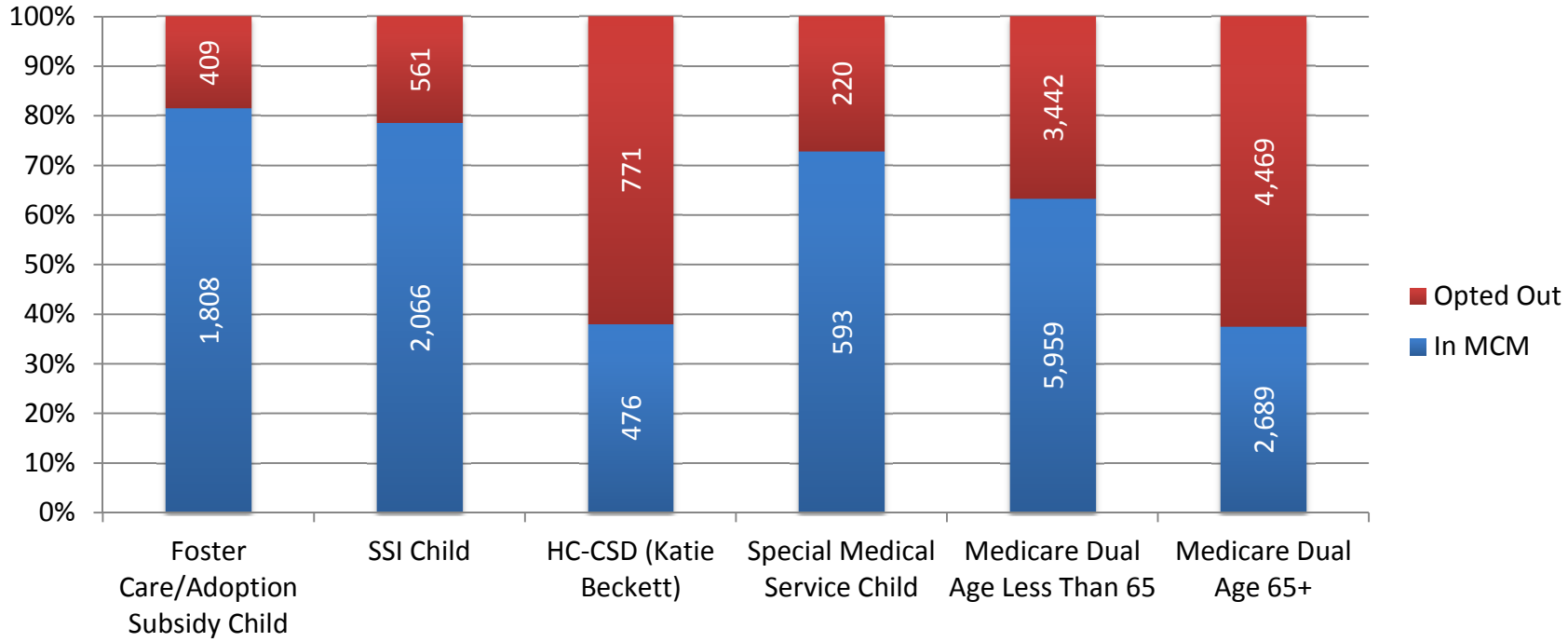
- The next two slides provide information about these individuals/populations



Blue- Those receiving Waiver services or Nursing Home services and currently enrolled with an MCO for their medical care.

Red- Individuals receiving Waiver services or Nursing Home services who will be required to enroll with an MCO for their medical care during Mandatory Enrollment

N=9,890. Data source: MMIS as of 6/4/2015



Blue- Individuals with complex needs who are currently enrolled with an MCO for their medical care.

Red- Individuals who will be required to enroll with an MCO for their medical care during Mandatory Enrollment.

N=23,463. Data source: MMIS as of 6/4/2015

Provider Outreach:

- Providers enrolled in Medicaid but are not yet enrolled with a Health Plan
  - DHHS provided list of providers to the MCO's
  - MCO's provided information during readiness review to support their efforts to outreach to these providers and encourage them to enroll with the Plan prior to Step 2, Phase 1 go-live date

Education, Training and Support
MCOs, Individuals, Providers

Intensive MCO Education and Training

- Provided by DHHS to ensure that the MCO's have the information necessary to serve individuals with complex needs in the Care Management program.

- Examples

  - Person Centered Planning
  - Providing Disability Competent Supports and Services
  - Overview of Home and Community Based Care Services
  - DHHS Eligibility Processes
  - Rights, Health and Safety including requirements for reporting Abuse, Neglect and Exploitation
  - Presentation of an Expert Panel of individuals receiving Long Term Supports and Services
  - Review of Choices for Independence Waiver and Nursing Facility participants currently served by the MCO's
  - DHHS Data Systems
  - MCM Program Quality Measures and Quality Strategy

Education and Support for Individuals with the Most Complex Needs

- DHHS agencies are identifying the clients with the most complex needs that will be transitioning from Voluntary to Mandatory status.
  - DHHS will outreach to the individuals, their families, guardians with educational and awareness materials.
  - NH Family Voices is collaborating with the Department on this effort.
  - Care coordinators and case managers who are currently working with these individuals are sharing information and will assist with the selection of the MCO that best meets their needs.
  - DHHS will share service utilization data with the MCOs (once enrolled) to anticipate needs and insure continuity of care across all service provision areas.
  - DHHS staff will conduct in person meetings with MCO staff before the MCO assumes responsibility for complex individuals to answer questions, provide context and to answer questions about current treatment regimens. Focusing on an individualized approach for these clients.

MCO Readiness Reviews

- Well Sense Health Plan: May 27, 2015
- New Hampshire Healthy Families: May 28, 2015
- Scope: Readiness Review for Step 2 Phase 1:
  - Assess the MCO's ability to serve the newly Mandatory Population and to identify strengths, unacceptable transition risks and assess the MCOs readiness to manage care for an increased number of complex individuals

MCO Readiness Reviews

Both MCO's were given case scenarios of individuals with complex conditions and were asked to demonstrate how they will address the needs of these individuals.

- The scenarios covered situations such as:
  - Management of members who have both private insurance and Medicaid specific to third party liability
  - Need for specialized Member Services and Care Coordination staff for members with complex needs seeking information from the Plan;
  - Differences in pharmacy utilization for members with intellectual/developmental disabilities such as the need for compounded medications, off label drug use, medications used at a higher dosage than typical for others and use of long term or "legacy" medications;
  - Differences in Prior Authorization processes for individuals with chronic, complex conditions vs. acute conditions; and
  - Understanding that individuals may have legal guardians or other authorized representatives and how the Plan can best interact with them.

Questions?